STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 00 B. WING	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA RD FORT WAYNE, IN 46818

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 1, 2, 3, 4, 5, 9 and 10, 2012 Facility number: 000255 Provider number: 155364 AIM number: 100273280 Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN Census bed type: NF: 109 SNF/NF: 2 Residential: 43 Total : 154 Census Payor type: Medicare: 1 Medicaid: 109 Other: 44 Total: 154 Residential Sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review 10/16/12 by Suzanne Williams, RN			

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F0162 SS=A	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart. Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving			

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	cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by			

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	§483.35 of this subpart. The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. Based on interview and record review, the facility failed to ensure 1 of 8 resident accounts reviewed was not charged for personal items covered by Medicaid. (Resident #67) Finding includes: 1. Review of the Resident Funds Accounts for Residents #67 conducted on 10/04/12 at 10:45 A.M., indicated the accounts had "shopping" withdrawals made routinely. Interview with Employee # 12, the CFO (chief financial officer) indicated the facility social service staff shopped for the residents. She indicated the residents requested specific items, and the facility staff shopped for the items. She indicated the itemized lists were not specified on the resident fund account statements, but the receipts were	F0162	**F 162 Limitations on Charges to Personal Funds What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** The Resident has been reimbursed the facility cost of items purchased to her resident fund account. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who choose to purchase their own care items have the potential to be affected by this practice. Beginning immediately, if the facility shops for the purchased items, the receipt will be turned into the business office for reimbursement. If the family shops for the resident, they will need to turn in the receipt to the business office for the	11/08/2012

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	kept and the facility was changing the policy and was going to start itemizing the "shopping" withdrawals. Review of the resident fund account for Resident #67, who received Medicaid monies, indicated a "shopping" withdrawal made on 09/18/2012 for "body was (sic) and wipes." According to the accounts, $4.00 was withdrawn, the items purchased, and $1.12 in change placed back into her resident fund account. Interview with Employee #12, the CFO, indicated she did not think the resident was only charged the difference in cost for the items purchased and the cost of the same items provided by the facility. Interview, on 10/04/12 at 1:20 P.M., with the Social Service Director (SSD) indicated the residents themselves were responsible for bringing the receipt to the office and requesting the difference be reimbursed, even if the facility staff had shopped and purchased the items for the resident. She indicated the facility kept all the receipts for the shopping for each resident. She indicated no resident had asked for the reimbursement for the items, even though they were notified upon admission of the policy.		reimbursement. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The business office, activity, and social services staff will be in-serviced about the regulations regarding reimbursement for residents when personal care items are purchased. As reminders for the families, will be put in the family newsletter on a quarterly basis that reimbursement is available for personal care items when a receipt is provided. For new admissions, residents and families will be informed of this practice. As reminders for residents, this practice will be reviewed quarterly at resident council meetings. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The Director of Resident Care and/or CFO will audit 10% of the receipts turned in monthly to ensure proper reimbursement to the residents has occurred. Results of the audit will be shared at the monthly QA meeting. Please see attachment #7	

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	Review of the facility policy and procedure, titled, "Goods and Services Covered by Medicare and Medicaid" indicated the both Incontinence care and supplies and bath soap were covered items provided by Medicare and/or Medicaid. In addition, the following note was indicated: "If you request a certain brand name of any items listed, we will shop for that item and only charge you the difference between our chosen item and your requested items." There were no instructions indicating the resident was responsible for requesting the difference for the brand name versus the facility brand if the facility had shopped for the resident. The policy indicated a price list of personal hygiene items was available upon request. Review of the Personal Hygiene Items, dated August 2012 included bodywash and shower gel. 3.1-6(j)			

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F0167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on interview and observation, the facility failed to post survey results in an easily visible and accessible location. This had the potential to affect all residents in the facility. Finding includes: 1. During the Environmental tour of the facility, conducted on 10/10/12 between 9:30 A.M. - 12:00 P.M., a sign was posted on a bulletin board in the main access hallway beside the stairwell and across from the elevator, indicating the state survey results were located in the "lobby." An unidentified resident who was seated in a wheelchair by the receptionist/snack desk was asked if she knew where the "State Survey" report was kept. She indicated she did not know the location of the report.	F0167	**F 167 Right to Survey Results – Readily Accessible** **What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** The binder has been changed to a white binder with black lettering so that it is easy to read. In addition, the binder will be located, free of chains, on the front counter in the lobby where the magazines are located. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by our survey binder not being readily available for their review. The aforementioned corrective actions will cover all	11/08/2012

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	The receptionist, Employee #13, indicated the report was kept in a dark blue three ring binder chained to the wall behind the receptionist/snack desk. The binder could not be removed, did not go all the way across the width of the desk so it could be accessed easily and read by residents and/or visitors. In addition, the binder was only labeled on the top in black letters. The unidentified resident, who was seated in her wheelchair by the snack desk, was queried if she could read the dark lettering on the dark blue binder when it was held up for her, and she indicated she could not make out the lettering. 3.1-3(b)(1)		residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The systemic change will be that we will no longer keep the binder secured to the wall but rather on the counter top free for all to take and read. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The front lobby staff will monitor the binder daily to ensure it is located at the front desk readily available for use. Please see attachment #1. The audits will be reviewed monthly at the QA meeting. This monitoring will occur for nine months.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview, observation and record review, the facility failed to initiate care plans for facial hair for 2 of 5 residents reviewed for ADL care plans. (Resident #75, Resident #32) Findings include: 1) Resident #75's record was reviewed 10/4/2012 at 8:46 AM. Resident #75's diagnoses included, but were not limited to, depression, arthritis, and Parkinson's tremors. During an observation on 10/02/2012	F0279	**F 279 Develop Comprehensive Care Plans** **What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** Both residents had their unwanted facial hair removed. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by unwanted facial hair. All residents were assessed for	11/08/2012

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	at 8:57 AM, Resident #75 was observed in the dining area. Long facial hairs were obvious when sitting across the table from the resident. When asked if the facility helped her with her long facial hairs, Resident #75 replied she had to ask for assistance and it embarrassed her to ask. On 10/03/2012 at 8:35 AM Resident #75 was observed in the dining area on second floor. Long facial hair remained obvious. A Quarterly Minimum Data Set (MDS) dated 7-25-2012 indicated Resident #75 required one person physical assistance to maintain personal hygiene including shaving. LPN #2 provided current CNA assignment sheet for review on 10/04/2012 at 8:53 AM. The CNA assignment sheet did not indicate Resident #75 was to be assisted with shaving. A Care plan, titled minimal assist for ADLs, dated 4/10/12 included interventions of encourage and praise independence with ADLs as ability allows, bath/ shower 2 x weekly, observe for decrease in ability, observe for and assist in completion		facial hair. Those residents found with facial hair were asked if they wanted assistance removing the facial hair. At which point, the facial hair was removed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Those residents who state a preference for facial hair removal will be care planned for assistance as needed. The C.N.A. assignment sheets will reflect the resident's preference. The in-service director will update the C.N.A. assignment sheet based on resident condition and any stated changes in preference concerning facial hair. Upon admission, all residents will be assessed by nursing staff for facial hair, preference. Any preferences for facial hair, and any required assistance with facial hair removal will be forwarded to the in-service Director or her designee, who updates the C.N.A. assignment sheet, and the Care Plan team, who updates the care plans. All nursing staff will be in-serviced on the proper use of the C.N.A. assignment sheet to ensure care is completed and resident preference for facial hair is honored. Residents will be asked quarterly, upon significant change, or as requested if their preferences remain the same. Please see attachment #2. **How the corrective action(s)**	

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	of tasks, offer verbal cues and physical prompts as needed, assist with meals, dressing, toileting, transfers, and etc. as needed, assist of 1 with gait belt for transfers, PT/OT as scheduled, tab alarm in bed and on chair, 1/2 SR x 2. There was no mention of assisting with facial hair removal. In an interview on 10/3/2012 at 8:10 AM, LPN #1 indicated facial care was completed every morning by the CNAs and any long facial hairs should be plucked or shaved off. LPN #1 further indicated Resident #75's need to have facial hair removed should have been addressed in a care plan. 2.) Resident #32's record was reviewed 10-3-2012 at 3:25 PM. Resident #32's diagnosis included but were not limited to high blood pressure,depression, and seizure disorder. Resident #32 was observed 10/02/2012 at 09:03:19 AM with beard growth more than stubbly. When asked how often he was shaved, Resident #32 shrugged. When asked if he wished to be shaved more frequently, Resident #32 nodded.		**will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** Nurse management will perform a 10% audit of those residents who have stated a preference for facial hair removal per the care plan and C.N.A. assignment sheet. Results of the audit will be reviewed monthly at the QA meeting. This monitoring will occur for nine months.	

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	During an observation on 10-3-2012 at 3:19 PM facial hair was not shaved. An MDS dated 8-21-2012 indicated Resident #32 was totally dependant for all care. Care plans were reviewed on 10-3-2012. No care plan addressed Resident #32's need to be shaved. In an interview on 10-3-2012 at 3:24 PM LPN #1 indicated Resident #32 should have had a care plan indicating his need for care. A current CNA assignment sheet provided by LPN #1 on 10-3-2012 at 3:24 PM indicated Resident #32 was to be shaved with electric razor, but not how often. 3.1-35(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician orders for laboratory tests for 1 resident of 3 reviewed for following lab orders (Resident #117). Findings include: Resident #117's clinical record was reviewed on 10/4/12 at 9:30 A.M.. The record indicated the resident had a diagnosis of deep vein thrombosis left lower leg based on an ultra sound of 8/29/12. On 8/30/12 a physician's order was received to start Coumadin 7.5 milligrams (mg) for one dose on 8/30/12 then start Coumadin 6 mg daily starting on 8/31/12. A physician's order was also received for a lab test for a Prothrombin Time/ International Rate (PT/INR) to monitor the Coumadin's effectiveness, to be done on 9/5/12. Review of the record indicated the PT/INR had not been completed. An interview with LPN #10 on 10/4/12	F0282	**F 282 Services by Qualified Persons/Per Care Plan What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** The resident's Coumadin was held that day and labs were ordered for the following morning. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who are on Coumadin have the potential to be affected by failing to follow physician's orders for lab tests. Nurse management reviewed all lab orders for all residents receiving Coumadin. Any discrepancy found would have been addressed immediately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** All nursing staff, including nurse managers, RN's, LPN's, QMA's, and C.N.A.'s will be in-serviced on the new procedures related to Coumadin administration and	11/08/2012

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	at 10:05 A.M. indicated the lab result for the PT/INR due on 9/5/12 could not be located. An interview with RN #11 on 10/4/12 at 11:35 A.M. indicated the PT/INR ordered to be done 9/5/12 was never completed. RN #11 indicated the resident had been asymptomatic for side effects related to an elevated PT/INR level, no excessive bruising or bleeding. RN #11 indicated a physician's order had been received to complete the lab test for a PT/INR on 10/5/12. 3.1-35(g)(2)		monitoring. Nurse Managers will implement a weekly monitoring of all new, routine, and changed medication orders for Coumadin and corresponding labs. Please see attachment #3. In addition, nurse management receives a weekly print out from the pharmacy of all residents on Coumadin at which time, they then ensure corresponding labs are ordered and obtained per physician's order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** All weekly monitoring of corresponding lab reports will be reviewed at the monthly QA. If there were any discrepancies found, a review of the corrective action taken will be discussed to identify further systemic changes needed. This monitoring will occur for nine months	

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	155364	A. BUILDING 00 B. WING	10/10/2012

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview, record review and observation, the facility failed to ensure facial hair was shaved for 2 of 3 residents reviewed with facial hair. (Resident #32, Resident #75) Findings include: 1) Resident #75's record was reviewed 10/4/2012 at 8:46 AM. Resident #75's diagnoses included, but were not limited to, depression, arthritis, and Parkinson's tremors. During an observation on 10/02/2012 at 8:57 AM, Resident #75 was observed in the dining area. Long facial hairs were obvious when sitting across the table from the resident. When asked if the facility helped her with her long facial hairs, Resident #75 replied she had to ask for assistance and it embarrassed her to ask. On 10/03/2012 at 8:35 AM Resident #75 was observed in the dining area on second floor. Long facial hair	F0312	**F 312 ADL Care Provided for Dependent Residents What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** Both residents had their unwanted facial hair removed. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by unwanted facial hair. All residents were assessed for facial hair. Those residents found with facial hair were asked if they wanted assistance removing the facial hair. At which point, the facial hair was removed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The Inservice Director will update the C.N.A. assignment sheet based on resident condition and any stated changes in preference concerning facial hair. Upon admission, all residents will be assessed by	11/08/2012

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	remained obvious. A Quarterly Minimum Data Set (MDS) dated 7-25-2012 indicated Resident #75 required one person physical assistance to maintain personal hygiene including shaving. LPN #2 provided current CNA assignment sheet for review on 10/04/2012 at 8:53 AM. The CNA assignment sheet did not indicate Resident #75 was to be assisted with shaving. A Care plan, titled minimal assist for ADLs, dated 4/10/12 included interventions of encourage and praise independence with ADLs as ability allows, bath/ shower 2 x weekly, observe for decrease in ability, observe for and assist in completion of tasks, offer verbal cues and physical prompts as needed, assist with meals, dressing, toileting, transfers, and etc. as needed, assist of 1 with gait belt for transfers, PT/OT as scheduled, tab alarm in bed and on chair, 1/2 SR x 2. There was no mention of assisting with facial hair removal. In an interview on 10/3/2012 at 8:10 AM, LPN #1 indicated facial care was completed every morning by the		nursing staff for facial hair preferences. Any preference for facial hair, and any required assistance with facial hair removal will be forwarded to the Inservice Director or her designee, who updates the C.N.A. assignment sheet, and the Care Plan team, who updates the care plans. All nursing staff will be in-serviced on the proper use of the C.N.A. assignment sheet to ensure care is completed and resident preferences for facial hair is honored. Residents will be asked quarterly, upon significant change, or as requested if their preferences remain the same. Those residents who state a preference for facial hair removal will be care planned for assistance as needed. The C.N.A. assignment sheets will reflect the resident's preferences. Please see attachment #2. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** Nurse management will perform a 10% audit of those residents who have stated a preference for facial hair removal per the care plan and C.N.A. assignment sheet. Results of the audit will be reviewed monthly at the QA meeting. This monitoring will occur for nine months.	

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	CNAs and any long facial hairs should be plucked or shaved off. LPN #1 further indicated Resident #75's need to have facial hair removed should have been addressed in a care plan. 2.) Resident #32's record was reviewed 10-3-2012 at 3:25 PM. Resident #32's diagnosis included but were not limited to high blood pressure,depression, and seizure disorder. Resident #32 was observed 10/02/2012 at 09:03:19 AM with beard growth more than stubbly. When asked how often he was shaved, Resident #32 shrugged. When asked if he wished to be shaved more frequently, Resident #32 nodded. During an observation on 10-3-2012 at 3:19 PM facial hair was not shaved. An MDS dated 8-21-2012 indicated Resident #32 was totally dependant for all care. Care plans were reviewed on 10-3-2012. No care plan addressed Resident #32's need to be shaved.			

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	In an interview on 10-3-2012 at 3:24 PM LPN #1 indicated Resident #32 should have had a care plan indicating his need for care. A current CNA assignment sheet provided by LPN #1 on 10-3-2012 at 3:24 PM indicated Resident #32 was to be shaved with electric razor, but not how often. In an interview on 10-3-2012 at 8:10 AM, LPN #1 indicated facial care was completed every morning by the CNAs, and facial hair should be shaved off. 3.1-38(a)(3)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure mattresses fit the bed properly, to ensure the bed was free from entrapment risk, for 1 of 4 residents reviewed for mattress gaps (Resident #67). Findings include: An observation on 10/1/12 at 10:30 A.M. indicated Resident #67's bed was noted to have a 5" gap at the top of the bed between the mattress and headboard. An observation on 10/5/12 at 10:05 A.M. again noted a 5" gap between the mattress and headboard at the top of the bed. An interview with the Director of Nursing (DN) on 10/5/12 at 10:10 A.M. indicated the facility had not noticed the gap in the resident's bed but they would fix the gap right away. The DN indicated the facility had received numerous new beds in July of 2012 and resident #67's bed was on of the new beds.	F0323	**F 323 Free of Accident Hazards/Supervision/Devices** **What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #67 had her mattress replaced with an 84" mattress. In addition, the facility purchased a 4" mattress extender for the 84" mattress thus lengthening her mattress to a total of 88". **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents will have their mattress measured to ensure proper fitting of the mattress to the head board/foot board. If a mattress is found to be more than three inches shorter than the bed's head board and foot board, a four inch extender will be added to the mattress. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** All mattresses will have three inches or less total gap from headboard	11/08/2012

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	Review of Resident #67's clinical record on 10-5-2012 at 10:45 AM indicated the resident had not suffered any accidents as a result of the gap between the mattress and the headboard since she received the new bed in July 2012. 3.1-45(a)(1)		to footboard with the addition of a four inch extender where needed. Any mattress purchased in the future will also meet these same guidelines. The Director of Environmental Services, or his designee, will be responsible for measuring the bed from headboard to footboard and ordering the appropriate sized mattress based upon the bed measurement. Please see attachment #4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The Director of Environmental Services, or his designee, will perform a 10% audit of resident beds to ensure the total gap measured between the headboard and footboard does not exceed three inches. Results of the audit will be reviewed monthly at the QA meeting. This monitoring will occur for nine months.	

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure interventions were attempted prior to administration of medication for sleep and failed to adequately monitor a resident receiving Coumadin, for 2 of 10 residents reviewed for medications (Residents #68 and #117). Findings include: 1. Resident #68's clinical record was reviewed on 10/3/12 at 11:00 A.M.	F0329	**F 329 Drug Regimen is Free from Unnecessary Drugs What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #68 did not have her Behavior Intervention Monthly Flow Sheet (BIMF) initiated to document behavioral interventions which occurred prior to PRN medication administration. Her BIMF has since been started. Resident # 117 had Coumadin held and labs taken the next morning. **How**	11/08/2012

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	Resident #68's diagnoses included but were not limited to insomnia, bipolar disorder, and diabetes. The record indicated the resident had a new physician's order from 9/6/12 for Benadryl 50 milligrams (mg) at bedtime as needed (PRN) for insomnia. The resident's Medication Administration Record (MAR) for 9/12 included a Behavior/Intervention monthly flow record which indicated the nurse was to "chart interventions before giving PRN med". Interventions were numbered 1 through 17: Intervention #16 indicated PRN medication (should not be first intervention). Review of the resident's (MAR) indicated the resident received Benadryl 50 mg at bedtime on 6 occasions. On 5 of the 6 occasions of receiving Benadryl 50 mg, no non-pharmacological interventions were attempted before administering the medication (9/9/12; 9/13/12; 9/17/12; 9/19/12; 9/22/12). An interview with RN #11 on 10/3/12 at 2:30 P.M. indicated non-pharmacological interventions should have been attempted on all occasions for insomnia before		**other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by failing to monitor behavior interventions prior to administering a PRN psychotropic medication. Nurse Managers will audit all resident M.A.R.'s for PRN psychotropic medications and ensure corresponding BIMF's are in place. If a PRN is found to not have a BIMF, one will be started immediately. Please see attachment #5. All residents who are on Coumadin have the potential to be affected by failing to follow physician's orders for lab tests. Nurse management reviewed all lab orders for all residents receiving Coumadin. Any discrepancy found would have been addressed immediately. Please see attachment #3. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** All licensed nursing staff will be in-serviced on the requirement to document behavioral interventions attempted prior to administering PRN psychotropic medication. Nurse manager's will implement a weekly monitoring of all new, routine, and changed medication orders for Coumadin and corresponding labs. Please see attachment #3. In addition,	

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	administration of Benadryl 50 mg in September 2012. 2. Resident #117's clinical record was reviewed on 10/4/12 at 9:30 A.M.. The record indicated the resident had a diagnosis of deep vein thrombosis left lower leg based on an ultra sound of 8/29/12. On 8/30/12 a physician's order was received to start Coumadin (a blood thinning medication) 7.5 milligrams (mg) for one dose on 8/30/12 then start Coumadin 6 mg daily starting on 8/31/12. A physician's order was also received for a lab test for a Prothrombin Time/ International Rate (PT/INR) to monitor the Coumadin's effectiveness, to be done on 9/5/12. Review of the record indicated the PT/INR had not been completed. No PT/INR had been completed since the physician's order on 8-30-2012. An interview with LPN #10 on 10/4/12 at 10:05 A.M. indicated the lab result for the PT/INR due on 9/5/12 could not be located. An interview with RN #11 on 10/4/12 at 11:35 A.M. indicated the PT/INR ordered to be done 9/5/12 was never completed. RN #11 indicated the resident had been asymptomatic for		nurse management receives a weekly print out from the pharmacy of all residents on Coumadin at which time, they then ensure labs are ordered and obtained per physician's order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** Nurse management will perform a 10% audit of those residents who have a BIMF and PRN psychotropic medication to ensure behavior interventions occur prior to medication. Results of the audit will be reviewed monthly at the QA meeting. This monitoring will occur for nine months. All weekly monitoring of lab reports will be reviewed at the monthly QA. If there were any discrepancies found, a review of the corrective action taken will be discussed to identify further systemic changes needed. This monitoring will occur for nine months	

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	side effects related to an elevated PT/INR level, no excessive bruising or bleeding. RN #11 indicated a physician's order had been received to complete the lab test for a PT/INR on 10/5/12 to monitor the effectiveness of Coumadin therapy. 3.1-48(a)(3) 3.1-48(a)(4)			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on interview and record review, the facility failed to post nurse staffing in a prominent location for visitor and resident review. This had the potential to affect all residents and/or residents families and visitors	F0356	**F 356 Posted Nurse Staffing Information What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice.** The nurse staffing	11/08/2012

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	in the facility. Finding includes: During the environmental tour of the facility, conducted on 10/10/12 between 9;30 A.M. - 12:00 P.M., the nursing staffing posting could not be located in the front lobby of the facility or at the nurse's stations on the three floors of the facility. Interview with Maintenance supervisor, on 10/10/12 at 9:30 A.M., indicated he did not know where nursing staffing was posted but thought it was on the staffing office door located on the first floor halfway to the kitchen area. Observation of the nursing staff development office door, located on unit 11 hall, approximately 1/2 way down from the nurse's station and main elevator bank, indicated a posting taped to the outside of the staff development office door. The door was covered with all kinds of staff information. The location of the staff posting was complete but was not located in a prominent location easily viewed by residents and/or visitors.		information will be posted in the front lobby. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the nurse staffing information being posted on the nurse supervisor's door. The nurse staffing information will now be posted in the front lobby. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** During normal business hours, the scheduler will be responsible for updating the nursing staffing information. During off hours, the nurse supervisor will be responsible for posting the nursing hours located in the front lobby. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The front lobby staff will monitor the staffing hours to ensure they are updated and posted per Federal guidelines. Please see attachment # 6. The audits will be reviewed monthly at the QA meeting. This monitoring will occur for nine months.	

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